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## Uncertainty work and temporality in psychiatry: how clinicians and patients experience and manage risk in practice?

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In psychiatric clinical practice, professionals pursue risk management alongside various uncertainties concerning diagnoses and treatment decisions. In this article, I draw on an ethnographic study of understandings of bipolar disorder in Finland to argue that risk management in psychiatry is better characterised as practical *uncertainty work*. I show how both the clinicians and the patients coordinate the uncertainties of bipolar disorder symptoms, risks and treatment decisions, into something that can be managed. I examine the ways in which temporality structures this uncertainty work and I explore two different modes of framing time. *Clinical time* stems from the current psychiatric thinking committed to the standardised diagnosis and the ideals of evidence-based medicine. Through this, professionals frame a task-oriented and linear treatment path from diagnosis and treatment to a managed life with bipolar disorder. *Experienced time*, in contrast, relates to the logics of care and self-care amid the embodied experiences of different actors. This framing of time involves a cyclical process where the patient, the clinician and the treatment interventions each need to adjust to changing situations.

**Keywords:** risk; uncertainty work; risk management; temporality; ethnography; bipolar disorder; psychiatry; clinician experience; patient experience

### Introduction

In this article, I use ethnographic data on understandings of bipolar disorder in Finland, showing in qualitative detail how clinicians and patients tackle diagnostic and clinical uncertainty in considering, assessing and managing patients' symptoms and treatment decisions. The argument I develop in this article is that, rather than technical risk management, it is the day-to-day *uncertainty work* through which 'risks' are handled by coordinating the contingent futures (see, Brown & Gale, 2018; Horlick-Jones, 2005; Pickersgill, 2010).

Through the analysis, I show how temporality is essential in this practical labour of professionals and patients. The uncertainty work in clinical encounters is structured by two different time frames: *clinical time* and *experienced time* (see, Alaszewski & Brown, 2016; Brown & de Graaf, 2013; Juhila, Gunther, & Raitakari, 2015; Klingemann, 2000; West, Newton, & Barton-Back, 2013).

Clinical time is related to the current psychiatric thinking committed to the standardised diagnosis and the ideals of evidence-based medicine. It frames diagnosis and treatment as a linear and task-oriented path aiming at a balanced situation in the patient's

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life. Experienced time, in turn, relates to the rationality of care and self-care and the embodied experiences of the actors. It refers to a processual time frame where the changes in the patient's experiences with mood swings forces changes in the interventions.

In the article, I show how the main tension between clinical time and experienced time lies in the different logics of care (Mol, 2008). The uncertainty work in psychiatric care involves coordination between these different logics. The aim is to adjust the standards and adapt to changing situations so that the individually suitable treatment and self-care become possible.

### **Risk and uncertainty in psychiatry**

Pat O'Malley (2004) has noted that in psychiatry clinical risk is not as stable as it might be in some other areas of medical care. Rather, clinical risk appears as an unstable assemblage in which diagnostic uncertainty and predictive risk can be entangled in different ways. Diagnostic uncertainty stems from the fact that despite the advances in understanding the mechanism of mental disorders in human mind, brain and body, there are no biomarkers by which to recognise a disorder or make treatment decisions. This persisting diagnostic uncertainty in psychiatry creates more uncertainties in clinical decision-making and in predictive risk reasoning (Hautamäki, 2016; Pickersgill, 2010; Rose & Abi-Rached, 2013).

### ***The standardised diagnosis***

In the absence of biomarkers, the distinction between normal and pathological moods, thoughts, emotions and behaviours is something that needs to be negotiated. One ostensible consensus formed in the psychiatric community is that represented in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which lists the symptoms of distinct mental disorders. The DSM forms the nomenclature in modern psychiatry and it is convergent with the *International Statistical Classification of Diseases and Related Health Problems* (ICD) of the World Health Organisation (WHO). These manuals are mostly used concurrently in clinical practice and, for instance, the Finnish clinical practice guideline for bipolar disorder recommends the use of both (Kaksisuuntainen mielialahäiriö, 2013).

The DSM system has encountered ample criticism regarding its ontological, epistemological, social and political problems (see, Callard, 2014; Cooper, 2004; Hacking, 2013; Holmes & Warelw, 1999; Insel, 2013). One key issue is that mental disorders are classified as clusters of symptom descriptions, which do not necessarily respond to the variety of ways individuals manifest mental ill health. This discrepancy not only complicates diagnosis and treatment in clinical practice, but it is also a problem in basic science because it is not clear whether the research object is human biology or mere symptom descriptions (Craddock & Owen, 2010; Insel, 2013).

Nevertheless, the diagnostic classifications standardise psychiatric practice by providing a mutual language, for actors from patients, psychiatrists and nurses to scientists, policy makers and pharmaceutical industry, through which to speak about mental disorders (Hautamäki, 2016; Lakoff, 2005; Martin, 2007). Yet, what is normal and what is pathological for an individual patient needs to be negotiated each time a diagnosis is reached in psychiatric care.

### ***Evidence-based medicine and clinical uncertainty***

In current psychiatry, there is a growing commitment to the principles of evidence-based medicine (EBM) in producing, organising and disseminating knowledge on the safety,

effectiveness and cost-efficiency of different treatment options. Evidence-based medicine is a strategy to reduce the uncertainty in clinical decisions (Armstrong, 2007) and it works through the clinical practice guideline. According to the ideals of evidence-based medicine, the recommendations of the clinical practice guidelines should preferably be based on evidence from randomised controlled trials, or meta-analyses of these, regarding the effectiveness of the intervention (Timmermans & Berg, 2003).

In psychiatry in particular, this ideal leads to a tendency of favouring drugs over other interventions, because the randomised controlled trial design is less suitable for assessing, for instance, different therapeutic interventions (Timmermans & Berg, 2003; Hautamäki, 2016, p. 63–95). The anti-depressant, anti-psychotic or mood stabilising drugs used in psychiatric care are often considered problematic in that these drugs alleviate the current symptoms of the patient but do not actually cure the underlying disorder. Moreover, these drugs can cause relatively harmful adverse effects and bipolar disorder patients have a relatively high mortality rate due to type 2 diabetes and coronary heart diseases. The treatment of bipolar disorder can, therefore, be a risk for the patient (Tyrer & Kendall, 2009).

The lack of truly efficient and safe pharmaceutical treatment options is partly due to widely discussed problems around industry sponsored pharmaceutical research in general (Williams, Martin, & Gabe, 2011), but the difficulty also lies in the fundamental uncertainty of psychiatric diagnosis: the research and development of pharmaceuticals is not based on targeting specific areas in the human mind, brain and body inducing the symptoms because in psychiatry these areas are not known (Busfield, 2004; Healy, 2008; Lakoff, 2007). In the everyday practices of mental health care, psychiatrists and patients need to work their way through these uncertainties in diagnosis and treatment decisions. This also affects the ways in which risk can be conceptualised and applied in the context of psychiatry.

### *Different understandings of risk*

The concept of risk has been used in several ways amidst the social science and health research on mental health care and psychiatry. Most obviously, the concept points to the probability of the psychiatric patient causing harm to others or self, and the ways to assess and manage the risk of future violent behaviour or suicide (see, Coffey, 2012; Heyman, Shaw, Davies, Godin, & Reynolds, 2004; Langan, 2010; Rose, 2010). Analyses of psychiatric thought styles grounded in governmentality perspectives identify a shift from practices of governing the risk posed by the dangerous insane, to the modern way of governing in the name of early intervention by identifying, assessing and managing risky individuals and populations (Castel, 1991; Helén, 2007; Rose, 1998; 2002; 2010). Mental health service users are also themselves subject to, and managing, various kinds of risks of harm from unsafe wards to adverse drug effects and stigma (Busfield, 2004; Kelly & McKenna, 2004; Quirk, Lelliott, & Seale, 2005; Ryan, 2000; Welsh & Brown, 2013).

The problem in applying the concept of risk in psychiatry is that, in the absence of clear biomarkers linked to specific mental disorders, the bundle of risk factors remains too vague and vast to have any real predictive value (see Mulder, Newton-Howes, & Coid, 2016; Szmulker, 2003). These vulnerabilities and risk factors span the life course and can be both social and biological. At the population level, mental well-being can be put at risk by such diverse phenomena as genetic predisposition, loneliness, insecure attachment in childhood, substance abuse or stressful life events. At the individual level, some of these risk factors, such as substance abuse or loneliness, can at the same time be interpreted as

manifestations of the mental disorder itself (Kaksisuuntainen mielialahäiriö, 2013; see Helén, 2007; Rose, 2010.)

In psychiatric practice standardised questionnaires, screens and rating scales are used to diagnose a mental disorder and to predict future harm. These technologies aim to serve as risk assessment tools or diagnostic tests and, thus, transform the clinical and diagnostic uncertainty into something that can be measured and calculated as ‘risk’ so that the risky individuals can be screened from the population (O’Malley, 2004; Rose, 1998, 2002, 2010). The clinical usefulness of these risk management tools has been found to be inadequate for many reasons, mainly because of the gulf between the population and individual levels of prediction (e.g. Godin, 2004; Holmes & Warelow, 1999; Large, 2013; Mulder et al., 2016).

### *Uncertainty work and time*

In this article, rather than concentrating on how risk is managed in psychiatry, I focus on the technologies and experiences that have emerged in response to the problems of clinical and diagnostic uncertainty (Samimian-Darash, 2011; Samimian-Darash & Rabinow, 2014). In the analysis, I draw upon Mol’s (2002; 2008) work and explore how the contingent and uncertain clinical reality is coordinated and stabilised in day-to-day practices of care. This coordination requires *uncertainty work*, by which I refer to the way both the clinicians and the patients, from their respective perspectives, have to work through the diagnostic and clinical uncertainty in psychiatry using things like diagnostic questionnaires or clinical practice guidelines (see, Brown & Gale, 2018; Gale, Thomas, Thwaites, Greenfield, & Brown, 2016; Horlick-Jones, 2005; Pickersgill, 2010).

I approach this uncertainty work in practice using ethnographic material collected within a case study of bipolar disorder diagnosis and treatment in Finnish mental health care. The diagnostic classifications used in psychiatry, define bipolar disorder as a mood disorder where periods of depression and mania or milder hypomania fluctuate. The fluctuation of these mood episodes is generally understood as varying from patient to patient, from rapid mood swings, even during a single day, to years with mild depression and only rare short periods of hypomania. Moreover, the patients can be asymptomatic for months and even years (see, Kaksisuuntainen mielialahäiriö, 2013).

The episodic nature of bipolar disorder brings out the importance of *time* when considering risks and uncertainties in clinical encounters (see, Alaszewski & Brown, 2016; Brown & de Graaf, 2013; Juhila et al., 2015; Klingemann, 2000; West et al., 2013). The onset of a serious illness can be interpreted as a disruption in the patient’s everyday life, normality and biography (Alaszewski & Brown, 2016; Bury, 1982). There seems to be an ideal path of coming into terms with the illness: from distress and worry to diagnosis, recognition, proper treatment and finally adopting an illness identity (Karp, 1994). A serious, and perhaps also chronic, illness creates uncertainty by disrupting the linearity of past, present and future in the patient’s biographical experience (Alaszewski & Brown, 2016).

In the organisation of psychiatric care, risk and uncertainty are also perceived in relation to the predictive knowledge derived from the past and the present of the patient’s life to prevent future harm or assess benefits (Alaszewski & Burgess, 2007; Samimian-Darash, 2011). The experiences of the patients’ personal time can sometimes conflict with the social or abstract time in health care, when the linear and standardised time of an organisation seems to oppress the patient’s experience of the illness in the present (Klingemann, 2000; Juhila et al.; Alaszewski & Brown, 2016).

In the remainder of this article, I discuss these aspects of time, risk and uncertainty in health care. In particular, I use the notions of *clinical time* and *experienced time*. Clinical time is represented in the ideal mental health care where standardised diagnosis is followed by evidence-based treatment and the patient's situation is well managed. Clinical time is abstract, standardised and linear, whereas experienced time is personal, changing and processual. Bergson's (2015 [1911]) concept of *duration* is relevant in conceptualising the nature of experienced time as a complex relational process of life in which past and present intermingle in the immediate experience (see, Tucker, 2012 ).

In this article, I seek to understand how uncertainty work by the patients and the clinicians is structured by temporality. I analyse the uncertainty work as a practical endeavour of clinicians and patients to coordinate the tensions between the linear clinical time and the processual experienced time (Mol, 2002, 2008).

## Methodology

To understand psychiatric care in practice, it is useful to focus on everyday experiences of different actors, professionals and patients, using ethnography as a method of investigation (Mol, 2002). The observations reported in this article are derived from a multi-sited ethnographic study conducted during 2009–2013 in Finland, where the focus was in the ways the unstable and uncertain object, bipolar disorder, was coordinated into something that could be researched, treated and experienced (Hautamäki, 2016). The study drew from a diverse set of data derived from three different sites: psychiatric science, clinical practice and patients' experiences. The data consisted of scientific and educational texts, observations in scientific conferences and online forums for patients, as well as interviews with scientists, clinician psychiatrists, nurses and patients with diagnoses of bipolar disorder (for details see Hautamäki, 2016, p. 19–28).

Multi-sited ethnography is a research design expanding from a single field to observations conducted within various sites for different periods of time (Marcus, 1995; Falzon, 2009; Hannerz, 2003; Nadai & Maeder, 2005; Wittel, 2000). Moreover, the research design is based on the idea that the observed sites can also manifest themselves, for instance, online or in scientific journals. All sources of gaining information from the sites are considered equally important grounds for the analysis (Nadai & Maeder, 2005; Wittel, 2000).

The data are summarised in Figure 1 and divided by site and type of data.

This article draws from the whole corpus of data, but focuses on the analysis of the clinicians' and the patients' experiences of uncertainty work in diagnosing, treating and living with bipolar disorder in Finland. I have particularly made use of the interviews with clinician psychiatrists, nurses and patients, as well as the observations on the patients' discussion forums, the psychoeducation material provided for the patients and the clinical practice guidelines for bipolar disorder diagnosis and treatment: *Kaksisuuntainen mielialahäiriö. Käypä hoito – suositus* (Kaksisuuntainen mielialahäiriö, 2013).

The setting in Finnish mental health care does not bring out any obvious differences to the rest of Western Europe in terms of how the standards of current psychiatric thinking are applied in the diagnosis and treatment. The majority of the treatment for patients with bipolar disorder is, however, provided by out-patient clinics and hospitals in municipal health care districts (Helén, 2007; Hautamäki, 2016, p. 19–28).

In keeping with common ethical research procedures, I have used informed consent forms and interviews have been anonymised before transcription and stored safely. In the use of the online data, I have applied the principles of ethical 'netnography' (Kozinets,



	TEXTS	OBSERVATIONS	INTERVIEWS
SCIENCE	Original articles in medical journals (59), dissertation summaries (7)	In conferences for psychiatrists (5)	Thematic in-depth interviews with scientists (10)
CLINIC	Reviews and original articles in Finnish medical journals (54), Clinical practice guideline + suppl.material	In Finnish resident training days for psychiatrists (4)	Thematic in-depth interviews with medical doctors in primary health care (7), specialised nurses (2)
PATIENT	Education for patients, published in print and online (16)	In the discussion forums (3) and blogs (3)	Thematic in-depth interviews with patients (3)

Figure 1. Table of the data.

2010): I gained permission to use the online material from relevant actors and I have anonymised this part by translating the quotations from Finnish to English so that search engines cannot be used to find the original posts.

## Findings

The findings focus on the ways temporality structures the mutual uncertainty work of professionals and patients in bipolar disorder care. I have constructed the sections in order to build the analysis from the diagnosis and treatment within the more abstract and organisational clinical time frame to the ways temporality frames the patients' experience of bipolar disorder and of personal time as a process. I describe how professionals adjust the ideals of standardised diagnosis and treatment to make the care of an individual patient possible; and how the patients adjust to the changing moods as part of their life. In the findings, I portray a practical work of reconciling the tensions between the clinical and the experienced time.

### *Tracing symptoms in the consulting room*

The psychiatrists I talked to all considered bipolar disorder as difficult to diagnose. The task for the clinician was to identify the symptoms of depression and mania or hypomania, as well as to establish a time frame for the patient's mood swings from up to ten years in the past to the present. The professional and the patient needed to find a mutual language to speak about bipolar disorder and to work through diverse uncertainties in remembering and interpreting the symptoms. The ideal standardised procedure of diagnosing bipolar disorder in Finnish psychiatric hospitals and out-patient clinics is outlined in the clinical practice guideline (Kaksisuuntainen mielialahäiriö, 2013).

In the guidelines, the symptoms of bipolar disorder are listed according to the diagnostic classifications. In bipolar disorder, the episodes of depression and mania (in bipolar disorder I) or milder hypomania (in bipolar disorder II) fluctuate across different



durations of time. Depressive episodes are characterised by low mood, poor self-esteem and loss of interest and pleasure in life activities ranging to suicidal thoughts and actions. Mania and hypomania are states of abnormally and persistently elevated, expansive or irritable mood combined with increased self-esteem and so-called behavioural symptoms, such as excessive interest in sex, shopping and engagement in risky business ventures. Between the mood episodes, the patients can experience long symptomless periods in their life even though the diagnosis remains (Kaksisuuntainen mielialahäiriö, 2013).

To reach a diagnosis, these symptoms are discussed in the consulting room according to the patient's account of his/her past and present life. One of the psychiatrists I interviewed described the challenges in providing an accurate description of past events:

It's like, at one point of time the patient might vividly describe his or her symptoms, and then at the next appointment deny such symptoms have ever taken place. The experience and the account of the patient tends to vary at different moments of time. (Psychiatrist, clinical work and research)

The clinician continued to elaborate that this is not only a characteristic of bipolar disorder patients' changing moods, but also reflects more generally the difficulties in remembering past events correctly and the communication problems stemming from the lack of mutual words to describe what depression and mania are.

To provide this mutual language and to aid the conversation between the clinician and the patient, the clinical practice guideline recommends several standardised questionnaires, interviews and rating-scales to be used in the diagnosis (Kaksisuuntainen mielialahäiriö, 2013). According to my observations, these pieces of paper worked as *diagnostic tools* mediating between the clinician and the patient. The diagnostic tools materialised the symptoms into something more tangible to be discussed in the consulting room and structured the time frame of different mood episodes in the patient's life.

#### *Ticking the boxes in the diagnostic tools*

The process of reaching a 'correct' diagnosis and the structure of discussion regarding the patient's symptoms and experiences were guided by the diagnostic tools. These questionnaires, semi-structured interviews and rating-scales address the symptoms of bipolar disorder or evaluate the patient's current mood episode and severity of the symptoms. Some of the tools are self-reported, paper-and-pencil questionnaires completed during an appointment, others serve as clinical interview protocols for the clinician.

Figure 2 depicts the diagnostic tools recommended in the Finnish clinical practice guideline on bipolar disorder to be used in the diagnostic process and later on in follow-up evaluation of the patient (Kaksisuuntainen mielialahäiriö, 2013).

The process starts with the patient reporting his/her symptoms in the *Mood Disorder Questionnaire* (MDQ). This is a brief screening of 13 yes/no questions about things like activity, sociability, foolish and excessive behaviour, use of money, interest in sex, troubles of concentrating, self-confidence, talkativeness – all derived from the symptoms of hypomania and mania in the diagnostic classification.

If the questionnaire indicates bipolar disorder, the process continues by interview protocols introduced in the DSM to confirm differential diagnosis. Then, to assess the gravity of the patient's mood episodes, the guideline recommends several rating scales, respectively, for the manic and depressive symptoms. In addition, the suicide risk is estimated with a separate scale (Kaksisuuntainen mielialahäiriö, 2013).

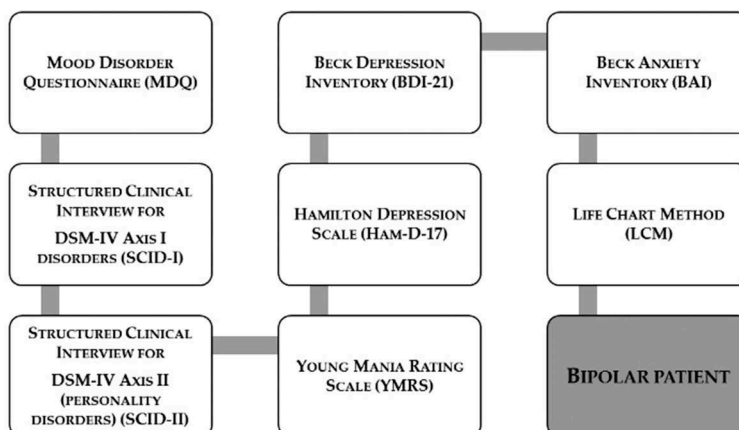


Figure 2. Process of becoming a bipolar patient.

Amongst the psychiatrists I talked to, these tick-the-box diagnostic and assessment methods were considered, on the one hand, as rendering clinical decision-making mechanistic and diminishing in-depth discussions with the patient. On the other hand, the tools were helpful in focusing on the symptoms. When I discussed the diagnostic tools with a psychiatrist in one interview, she pointed out that the diagnostic classifications with distinct code numbers for each disorder were mere technicalities:

But, it doesn't really matter, it doesn't guide the treatment, what number you have there. Psychiatrists are a bit bohemian, you know, they do consider what they are treating. The numbers are then in a way only for the registers. (Psychiatrist, clinical work and research)

This excerpt indicates that it is fundamental for the art of clinical work in psychiatry to be 'bohemian' enough to adjust the standardised diagnostic categories to meet an individual patient's situation and indeed consider what kind of disorder is being diagnosed and treated. The psychiatrist felt it was possible to use diagnostic tools to work through the uncertainty without losing one's awareness of the nature of the diagnostic categories or the ability to be present and listen to the patient.

### *Integrating mood episodes into a biographical timeline*

The diagnostic tools introduced above are employed by clinicians in addressing the patient's situation in the present. To trace back the past mood episodes in the patient's life, the clinician can use the Life-Chart Methodology (LCM), which is a self-reported chart, assessing the patient's life retrospectively for the past five or ten years. In the chart, the patient completes his/her past mood episodes, symptomless periods, medication, possible hospitalisations, alcohol and substance use, as well as symptoms of anxiety and other mental disorders. In addition, the patient is asked to report any stressful life events. These are considered as risk or trigger factors influencing the onset of the mood episodes (Kaksisuuntainen mielialahäiriö, 2013).

The *Life-Chart Methodology* structures a time frame for the patient's illness history and a completed chart visualises the mood episodes as ups and downs around the intermittent symptomless periods. One of the clinicians described the *Life-Chart Methodology* as a tool

for the patient to situate the mood episodes among the ‘high-school graduations, marriages, children born, divorces, what have you’. The tool integrates the mood episodes into the patient’s biography. Even though it is obviously hard for the patient to recall what took place during the elated phases of mania or in the deepest hollows of depression, the professionals thought it was also meaningful and potentially illuminating for the patient to integrate the mood episodes into a timeline of life events. The professionals described this process as helping the patient to realise and accept the bipolar disorder diagnosis.

This tool brings the patient’s biography into the clinical encounter to aid the professional in the diagnosis and, at the same time, encourages the patient to recall and reflect on their past. I interpreted the use of the *Life-Chart Methodology* as a way of coordinating between the patient’s experienced time – the personal life events – and the abstract clinical time framing a timeline of mood episodes amid the standardised process of diagnosing bipolar disorder in a consulting room of an out-patient clinic.

All the different diagnostic tools were fundamental for the practical uncertainty work in clinical encounters. The tools provided something tangible for both the clinician and the patient to work with and help to verbalise the symptom manifestations of bipolar disorder as well as integrate the mood episodes into the patient’s past and present life. Furthermore, even though the tools did not provide a clear-cut solution to the problem of diagnostic uncertainty, they stabilised and coordinated the situation in one moment of time so that it was possible to reach a diagnosis and plan for the treatment.

Importantly, the ‘bohemian’ psychiatrists carried out uncertainty work in a pragmatic manner. The professionals adjusted the ideal of a straightforward, timely and efficient diagnostic process to the flows and fluctuations in the patients’ present situations and past experiences.

### ***Evidence-based treatment standard***

One of the documents that provided me with information on the standards of bipolar disorder treatment was the clinical practice guideline, which is a tool by which evidence-based medicine works in practice. The clinical practice guideline was used in day-to-day practice of psychiatrists and it was an important part of tackling the uncertainty in diagnosis and treatment decisions. The guideline summarised the evidence-based standard for bipolar disorder treatment as follows:

Bipolar affective disorder (BD) is a long-term mental disorder. (...) It is related to a serious risk of self-destructive behaviour. (...) Treatment focuses on preventing the recurrence of mood episodes. The care is based on mood stabiliser and second generation antipsychotic medication in accordance with the patient’s current symptoms. When added to pharmacotherapy, psychosocial interventions can improve the outcome. (Kaksisuuntainen mielialahäiriö, 2013)

Bipolar disorder is conceptualised here as a *long-term* mental disorder, a life-long illness that is perhaps never fully cured, but can be cared for and managed by ‘*preventing the recurrence of mood episodes*’. The standard treatment for bipolar disorder is a combination of so called mood stabilisers and/or antipsychotics, antidepressants and sedatives. As the clinical practice guideline states ‘*psychosocial interventions can improve the outcome*’, but are not the main treatment option.

According to my observations, the clinical practice guideline represents an ideal for a treatment path in mental health care. It starts with the diagnosis, followed by the medication plan aiming at stabilising the current mood episode and continuing with

psychoeducation, follow-up and plans for the prophylactic long-term medication. This treatment path is structured by the organisational clinical time so that the patient would ideally receive treatment in out-patient clinics around maximum 3 years of active intervention, after which the patient is supposed to be able to balance the symptoms independently (Kaksisuuntainen mielialahäiriö, 2013).

The professionals I interviewed often underlined one important aspect in bipolar disorder treatment, that of adherence. It was sometimes difficult to keep up the planned medication, because patients did not wish to be treated while in the manic or hypomanic phase or complained about the adverse effects of the drugs. The clinical practice guideline informs the clinician of the importance of treatment adherence and emphasises the role of psychoeducation in helping the patient adjust to the idea of a life-long medication (Kaksisuuntainen mielialahäiriö, 2013).

According to my observations, the patients had very tangible reasons for non-adherence to the medication. Patients commonly described the ways drugs might have eased the symptoms of bipolar disorder but at the cost of negatively impacting on their emotions and cognition. On the online discussions I observed, the known adverse effects of mood stabilisers and antipsychotics were a frequent topic. The patients complained of having extrapyramidal symptoms like cramps, compulsive movements, different kinds of cognitive dysfunctions, as well as heart problems, constipation and metabolic symptoms such as weight gain.

The drugs used in psychiatry are not harmless and their effects vary from one patient to another. Therefore, the clinical practice guideline points out that the medication needs to be tailored to the patient's 'individual harm-benefit ratio', keeping in mind the risk of self-destructive behaviour and the risks of the treatment itself (Kaksisuuntainen mielialahäiriö, 2013).

### *Tinkering with the pharmaceutical cocktails*

The episodic nature of bipolar disorder inevitably means that the clinical practice guideline recommends various combinations of different drugs to control the symptoms (Kaksisuuntainen mielialahäiriö, 2013). Both the patients and the professionals described how arduous it was to find the right combination for the patient's individual needs. One of the psychiatrists described this uncertainty work in the following way:

In some patients, it [the combination of drugs] hits the mark right away, and then in some patients it feels like it is very hard to find the drug that would work and not cause too much adverse effects. Always when a treatment does not work, you go back to square one, and wonder why this does not work. Is the diagnosis wrong or might there be some factor that you have not taken into account or is the patient actually taking the medication at all? (Psychiatrist, clinical work and research)

As this psychiatrist describes, the everyday clinical practice cannot be fully predicted and rationalised. There were many reasons for the well-planned combination of drugs not to succeed in managing the patient's symptoms. Sometimes the clinician had to return to the beginning of the structured treatment path and open-up the initial diagnosis for consideration.

The patients talked about this task of finding the right medication as an ongoing process and an embodied experience. The problems they experienced were related to the various ways pharmaceuticals affected their thoughts, feelings and bodies. They commonly referred to the adverse effects of mood stabilisers or antipsychotics such as feeling

numb (unable to feel the whole spectrum of emotions), reduced cognitive performance, rapid weight gain, tremors, uncontrollable tongue movements, restless feet or constipation. The patients described how the combination of adverse effects changed as new drugs were tried out.

Both the patients and clinicians also referred to difficulties in recognising which of the various effects of the drugs were more and less beneficial. Consider, for instance, this patient's description of what happened when the antipsychotic she was using was changed to another:

I have noticed that now that I have been using Abilify [aripiprazole] for 5 months, so much more emotions come through than it did with Risperdal. I mean, it seems like Abilify doesn't make you numb, which is nice. But then again, it brings anxiety, tearfulness, anger, and seems like the joyful feelings are stronger as well. I am using benzodiazepines to lessen this surge of emotions, but it feels weird to be this out of control when the moods just take over. I used Risperdal [risperidone] for 10 years and got used to the numbness, but back then I, like, laughed out loud in my grandfather's funeral because of the stupor from the antipsychotics. Do I have to get used to this emotionality or find some other drugs to support me? I also use Xanor and Sepram' [alprazolam and citalopram] (Patient on a discussion forum)

This patient was talking about the way she managed uncertainty resulting from changes in medication. Each change of drug combinations involved a readjustment. She was dealing with differing types of adverse cognitive and emotional effects which she saw as being linked to the different combinations of antipsychotics (*Abilify* and *Risperdal*), sedatives (*Xanor*) and antidepressants (*Sepram*). For the patient, this process of adjusting to the changing situations could last for years.

The professionals' task of finding the right combination of medication for the right patient was informed by the evidence-based knowledge in the clinical practice guidelines. However, to grasp the patient's situation in their everyday clinical practice, professionals referred to a need to coordinate different registers of knowledge: the accounts of changing symptom experiences by the individual patient and the epidemiological knowledge of the averages concerning the effects and adverse effects of drugs.

### *Psychoeducation and mood diary in managing the daily life*

In addition to the long-term medication, the clinical practice guideline recommended psychoeducation to improve the patient's adherence to the treatment and to provide psychosocial support in managing life with the disorder (Kaksisuuntainen mielialahäiriö, 2013). The influence of these guidelines was apparent in group-based psychoeducation courses. I discussed the issue of psychoeducation with two nurses responsible for running the courses in an out-patient clinic. The nurses told me that these courses were designed to provide information with the aim of helping the patient to adjust to the illness and (better) manage symptoms and related experiences.

The courses took three to six months and convened once a week for an hour and half to two hours. The groups usually had a theme for each day, covering topics such as: how to recognise symptoms of bipolar disorder; the triggering factors of a mood episode; or how to detect the symptoms as early as possible and how to learn stress-management techniques. In line with the aims of psychoeducation, the group participants were encouraged to adopt a daily routine of keeping a specific *mood diary*.

The mood diary, or a mood calendar, was a tool designed for the patient to keep track of the symptoms on daily basis. In the diary, patients were asked to report their current

mood, medication taken, hours slept, alcohol intake, exercise and diet, as well as stressful life events – from petty quarrels with loved ones to losing a job. Women were also asked to report their menstrual cycle in the diary. All these are considered as factors that might in one way or another affect the onset of the mood swings. In Figure 3, there is an example of a mood diary provided online by the pharmaceutical manufacturer Eli Lilly, which I have filled in with fictional information to provide an illustration.

In the discussion forums I observed, the patients talked about their ways of personalising and modifying the mood diary by, for instance, inventing their own codes to note the moods of the day. One participant described how, at the end of the month, she conducted research on her own data by searching for correlations between different moods and medications, exercise, diet, menstrual cycle, sleep patterns or life events.

The use of the mood diary is recommended in the clinical practice guideline as an efficient tool in psychoeducation to increase the patient's adherence to treatment and to promote self-awareness of the symptoms (Kaksisuuntainen mielialahäiriö, 2013). One of the psychiatrists I interviewed described the use of the mood diary in the following way:

It's a good tool for communication particularly when the patient fills in the diary repeatedly and also compares the symptoms herself/himself. Like, why is this symptom appearing now? Or what kinds of symptoms did I have then compared to what I have now? (Psychiatrist, clinical work and research)

MONTH: APRIL YEAR: 2014 WEIGHT: 60

Fill in the circle that describes your mood each day.

DAYS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Severe																															
Moderate																															
Mild																															
STABLE																															
Mild																															
Moderate																															
Severe																															

Did you experience any of the following symptoms? If yes, fill in the circle.

Anxiety																															
Irritability																															
Mood swings																															

Record hours slept

Record hours slept																															
--------------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Alcohol consumed

Alcohol consumed																															
------------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Menstrual cycle

Menstrual cycle																															
-----------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**DOCTOR'S NOTES:**

Did you take your medication(s) today? If yes, fill in the circle.

Did you take your medication(s) today? If yes, fill in the circle.																															
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Were you physically active today? If yes, fill in the circle.

Were you physically active today? If yes, fill in the circle.																															
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**How did you feel today?**  
[i.e., Were there any significant life events that could have had an effect on your mood?]

Figure 3. Mood diary.



The professionals believed the mood diary could indeed increase the patient's awareness of the temporal flow of his/her symptoms and of the triggers behind the symptoms. The mood diary provided salient information for the professional adjusting the treatment, but also fostered communication between the clinician and the patient. Together the mood diary and the *Life Chart Methodology* can be considered as generating a visualisation of the patient's fluctuating mood throughout life course, from small-scale daily episodes to larger-scale changes across months or years. According to my observations, the mood diary connects to the continuum of the diagnostic tools that intensify the focus on temporality in clinical encounters by connecting the past, present and future experiences into something more tangible to work with.

Clinicians used the mood diary in the context of evidence-based treatment standards as part of the task-oriented way of planning and assessing the patient's treatment and keeping up with the changes in the patient's life. Whereas for the patients, the uncertainty work using the mood diary was a daily activity through which they could structure their symptoms and personal experiences, as well as visualise the changing mood episodes in time.

### ***The tension between clinical time and experienced time***

In contrast with those moments when the patient was engaging with clinical time in the consulting room, the experience of everyday life with the disorder was marked by constant change. The patients' experienced time appeared to be an ongoing process of becoming – perhaps every time slightly differently – bipolar. Consider this patient's pondering on her changing symptoms:

I don't know what is going on. It feels like I'm swinging and swaying and crying, but now [I am] in a quite good mood again. A change for the good perhaps? But then again if I think of the previous symptoms, these are not so bad yet. But it still feels like everything is not ok. Today I have been lively. I have had a couple of horrific days with anxiety and impulses, so I wonder if this might be a mixed episode or is it just stress from the change in my mood? Today I started to wonder, do I really know what my normal mood is? Maybe this healthy joy of life and good mood today is the normal me? Should I just stop defining myself all the time? (Patient on a discussion forum)

In this excerpt, the patient was analysing her moods in the present moment while also contrasting these experiences to her past. She was trying to trace her own normal mood or the 'normal me'. But, as reflected in other accounts, this patient described difficulties given that memories recalled from the past were inevitably entangled with the experiences in the present shaped by bipolar disorder.

A bipolar disorder diagnosis entailed change in the patients' biographies, but it was not abrupt. Rather the patients described a gradual process of changes as they adjusted to the swinging moods and all the other aspects affecting their experience: the effects of drugs, reflections of symptoms in daily mood diaries, meditation, dietary and exercise regimes, alcohol and coffee intake, sleeplessness and connecting with peers in psychoeducation groups or professionals in mental health care. The personal and experienced time for the patients was not engaged in organising past and present, but adjusting to the changing process and managing life in the here and now.

The experienced time as a process seemed to be in tension with clinical time framing an ideal path for the patient in psychiatric care: the standardised diagnosis followed by evidence-based treatment with well-managed medication and psychoeducation.



Psychiatric care in practice needed the uncertainty work of adjusting the diagnostic classifications and tinkering with the combinations of drugs.

The psychiatrists described their own embodied experiences and different ways of coping with these tensions. One of the psychiatrists I interviewed explained how she felt it was easier to treat psychotic (schizophrenic) patients. She described how she could not directly relate to psychotic experiences, whereas the mood swings of bipolar disorder were more familiar and tangible for her. This is how she described her experiences:

I feel that it [treating bipolar disorder patients] really sucks the energy and the strength out of you, because it is so important that the treating professional is capable of keeping up hope and optimism towards the future. And there are so many different situations within the patients, some are in a good phase with their recovery and then there are the suicidal ones. That is really hard also for the professional treating the patient. (Psychiatrist, clinician)

Even where the treatment process was marked by the task-orientation and efficiency of clinical time, the professionals referred to how important it was nevertheless to take the time to relate to the patients' varying situations and, as the excerpt shows, keep up some aspects of hope and anticipation of better futures for the patient. The main tension between the time frames was not so much represented as a power relation between the psychiatrist and the patient, but rather the tension appeared to be rooted in contrasting logics of care: clinical time framed standardised treatment paths, whereas experienced time framed an ongoing process of care and self-care in constantly changing situations.

## Discussion

In this article, I have developed an analysis of day-to-day uncertainty work carried out by professionals and patients in the context of psychiatric care (Brown & Gale, 2018; Gale et al., 2016; Horlick-Jones, 2005; Pickersgill, 2010). In my analysis, I focused on understanding how the professionals and patients work with the uncertainty in the diagnosis and treatment of bipolar disorder, and paid attention to the different temporalities structuring this uncertainty work. In the findings, I portrayed the practical work of resolving the tensions between the clinical and the experienced time.

### *Uncertainty work in psychiatric care*

I started the analysis with findings from the process of reaching a bipolar disorder diagnosis and constructing a treatment plan within the clinical time frame. The diagnosis was a mutual work of the professional and the patient in attempting to interpret the past and present symptoms manifestations and experiences of the patient in the context of what the diagnostic classifications characterise as bipolar disorder.

Using an array of different diagnostic tools, the 'bohemian' clinicians applied the standards in a pragmatic way. Instead of slavishly following the structured and task-oriented process, the professionals focused on the individual variance in the symptom manifestations. The *Life-Chart Methodology* employed within the services was of particular interest, because this diagnostic tool coordinated between the patient's experienced time – the personal life events as a biography – and the abstract clinical time framing a timeline of mood episodes amid the standardised process of diagnosis.

The tick-the-box diagnostic questionnaires were used to assess and measure patients' individually experienced moods, thoughts, feelings and behaviour. These tools served to

stabilise the uncertainty in the clinical encounter but diagnostic tools can transform psychiatric practice into a technical performance undermining the importance of the clinicians' experience and knowledge (Godin, 2004; Large, 2013; Mulder et al., 2016). These medical technologies have emerged as solutions to the problem of diagnostic uncertainty in psychiatry but, as Nikolas Rose (1998; 2002; 2010) has noted, the tools can be used as 'risk' technologies in screening the risky individuals from the population in the name of early intervention (see Castel, 1991; Holmes & Warelw, 1999).

In current psychiatry, the ideals of evidence-based medicine structure the ways care is organised. Evidence-based medicine works through the clinical practice guidelines, by which medical technology reduces uncertainty in diagnosis and treatment (Armstrong, 2007; Timmermans & Berg, 2003). The clinical practice guideline for bipolar disorder suggested a task-oriented treatment path where the patient ideally receives a timely diagnosis and effective treatment resulting in quick rehabilitation and discharge. This treatment path is marked by clinical time and ideally it proceeds in a structured and standardised manner.

In my analysis, I showed how this ideal treatment was adjusted to the changing situations by the professionals. Bipolar disorder treatment was focused on finding the right combination of drugs to fit the individual patient's needs in a situation where the available drugs can cause challenging and harmful adverse effects (Tyrer & Kendall, 2009; see Busfield, 2004; Lakoff, 2007; Healy, 2008). There was a constant need for the professional and the patient to weigh up the wanted and unwanted effects of the medication in changing situations. Hence, the uncertainty work of the professionals was needed to coordinate the accounts of the individual patients' symptoms and experienced adverse effects with the evidence-based knowledge on best treatment.

The uncertainty work stabilises the contingency in psychiatric care so that a diagnosis can be placed and the patient treated. However, when the situations change, new uncertainties may arise (see, Giddens, 1991). For instance, if the medication was not working as hoped, the clinician had to return to the beginning of the structured treatment path and open-up the initial diagnosis for consideration. The persisting diagnostic uncertainty created new uncertainties in clinical decision-making (Hautamäki, 2016; Pickersgill, 2010; Rose & Abi-Rached, 2013).

### *Coordinating different temporalities*

Alongside the analysis of the day-to-day uncertainty work, my findings showed how temporality structures bipolar disorder diagnosis and treatment in psychiatric care. I used the ways of characterising time, clinical and experienced time, to differentiate the abstract and linear time of the organisations from the personal and processual time experienced by the actors, particularly the patients who live with their constantly changing moods due their illness.

Clinical time is related to the ideals of standardised and evidence-based diagnosis and treatment. Clinical time frames a straightforward treatment path in mental health care and implies an imperative of improvement over time. The findings showed how time was intensified in the processes of reaching a diagnosis and considering treatment options in psychiatric care. Patients' experiences of personal time can conflict with the abstract time of health care organisations. The linear and standardised time of an organisation can take over the patient's experience of the illness in the present (Alaszewski & Brown, 2016; Juhila et al., 2015; Klingemann, 2000). This phenomenon was apparent in my findings as well, but clinical time seemed to challenge both the patients' and the professionals'

experiences. The psychiatrists needed to coordinate between the clinical time and experienced time in their uncertainty work.

Experienced time is related to the lived experiences of the professionals and particularly the patients. The experienced time for the patients is part of the cyclical process. In my findings, there was a cycle of self-reflection in the diagnostic process, the embodied experiences of medication, psychoeducation and peer support, various self-care methods and self-reflection of the moods in day-to-day life with bipolar disorder. The daily mood diary routine was a tool for psychoeducation, but also generated these processes of self-reflection on what is normality. In this process, the patient and the treatment in psychiatric care or self-care adjust to the constantly changing situations shaped by experiences amid bipolar disorder. The patients' experience of time can be characterised as an embodied *duration*, with its individual rhythm in the immediate experience. The patients' past, present and future experiences, as well as the interventions to their minds, brains and bodies, influence one another in a complex relational process (Tucker, 2012 ; Bergson, 2015 [1911], 272).

To receive a diagnosis of a serious and life-long illness can disrupt the patient's everyday life, normality and biography (Alaszewski & Brown, 2016; Bury, 1982). In my findings, the patients' lives were not so much disrupted and they did not adopt a straightforward illness identity (Karp, 1994). Instead the patients slowly lived through the process of becoming bipolar and this experience was influenced again by the diagnosis and treatment they received in psychiatric care and the self-care practices they adopted. The experience of bipolar disorder might be different from, for instance stroke, just because the illness is not abrupt and it can take even ten years from the first onset of the symptoms to the diagnosis (Alaszewski & Brown, 2016).

Hopeful horizons into future were not tangible in my findings (see, Brown & de Graaf, 2013; Ryan, 2000). The treatment plans and decisions were made to tackle various uncertainties, with hope as something that unfolds in the adjustment to the changing situations more than anticipating better futures (Tucker, 2012). Juhila and others (2015) analysed the joint future talk of patients and professionals in mental health rehabilitation plan meetings. They observed, how the linear time frame and future plans were usually challenged by the patient's state of mind and needs in the present – or what they called 'mindful body time'. In my analysis, the patients also tended to live more in the immediate experience and the professionals felt it was their responsibility as part of good care to provide them with hope. Moreover, the professionals felt the challenge of coordinating between the individual patient's experienced time and the challenge of adhering to the evidence-based ideals of linear and progressive treatment.

In my findings, the main tension between clinical time and experienced time was in the different logics of care (Mol, 2008) and the standardised, task-oriented and abstract logic seems to give way to the professionals' and the patients' pragmatic adjustment to the changing situations.

### ***Conclusion: working through risk and uncertainty in psychiatric care***

Psychiatric care deals with a combination of predictive risks concerning adverse effects of drugs or probabilities of self-harm and diverse uncertainties in diagnosis and treatment (O'Malley, 2004). The absence of biomarkers by which to recognise mental disorders maintains diagnostic uncertainty in psychiatric care (Craddock & Owen, 2010; Insel, 2013). The uncertainty in psychiatric treatment, particularly in such episodic illnesses as bipolar disorder, stems from the difficulty in finding the right medication for patients with

very varied problems, needs and responses to medicines, and who are often in the midst of changing situations and needs (Lakoff, 2007; Tyrer & Kendall, 2009).

Evidence-based medicine and standardised diagnostic classifications are solutions to these uncertainties. These solutions work through the clinical practice guidelines and various standardised questionnaires, rating-scales and interview protocols (Armstrong, 2007; Pickersgill, 2010). The public health strategies in mental health care aim at prevention and early intervention, but the standardised and technical risk management does not fully resolve the complexities in everyday psychiatric care (Helén, 2007; Rose, 1998, 2002, 2010). Based on the findings in this article, I argue that rather than technical risk management, the risks are handled through uncertainty work in situated care practices.

The practical uncertainty work psychiatrists, nurses and patients carried out in their everyday care and self-care practices was a solution to the problems of clinical and diagnostic uncertainty in psychiatry (Samimian-Darash & Rabinow, 2014). Indeed, instead of the technical risk management, the solutions can lie in small and mundane decisions in care practices (Mol, 2002; 2008). These decisions are situations where professionals and patients coordinate diverse contingencies so that, despite the uncertainties, mental disorders can be diagnosed and treated accordingly.

As Alaszewski and Brown (2016) note, risk and uncertainty are time-oriented concepts. In health care different temporalities – social, personal and abstract – are related to the ways risks and uncertainties are handled. Risk assessment in health care is dependent on past knowledge, calculation and evaluation, whereas uncertainties are managed in the more mundane care practices. In this article, I showed how there was a tension between clinical time and experienced time. I have also showed that this tension was rooted in contrasting logics of care: standardised and evidence-based treatment paths and an ongoing process of care and self-care in constantly changing situations. The clinicians and patients worked amid this tension by adapting the standards and adjusting to situations creatively. Perhaps by relying on this pragmatic logic of care, the uncertainty work might also have managed future probabilities of, for instance, self-harm or recurring illness episodes.

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